From shadow to spotlight: an advocacy for the academic underpinning of psychiatric liaison

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Abstract

Settings offering services by liaison psychiatry (LP) and associated human resources have increased over the last decades. While the psychiatric consultation (PC) activity has actually grown, the psychiatric liaison (LI) activity, which aims to build a bridge between psychiatric and medical expertise and to transfer knowledge to support clinicians who care for the medically ill, is still doomed to a shadowy and stagnant existence. In this commentary, we will focus on the challenges LP, and especially LI are facing and call for a change in perspective to tackle them.

Reflections on the development of psychiatric liaison

The aim of this paper is to provide a short overview of the development and current state of liaison psychiatry (LP) and its psychiatric consultation (PC) and liaison (LI) activities and to make a call for a change in perspective regarding LI. We do not claim comprehensiveness and objectivity of our observations, which are largely experience based. Indeed, examples from the local clinical and academic activity by the authors support the argument of this paper.

LP, also known as *consultation liaison psychiatry* is the branch of psychiatry that focuses on the interface between somatic medicine and psychiatry. The role of PC activity is to provide psychiatric and psychotherapeutic care for the medically ill with psychiatric morbidities or psychological problems at the request of the treating medical or surgical team. The role of LI activity is to work with referring colleagues in different ways and for a variety of reasons (e.g., transfer of psychiatric knowledge, support, etc.) (1). LP teams usually consist of psychiatrists, psychologists, psychiatric nurses, and social workers. In some countries, LP overlaps and/or is covered by neighborhood disciplines like psychosomatic medicine or medical psychology. However, psychosomatic medicine and medical psychology are clinical approaches whose purpose is to interlace the psyche and the body, which can be also partly provided by specifically trained general practitioners.

In the middle of the last century, when general hospitals started to call on psychiatrists for the treatment of the medically ill with mental health comorbidities, referrals were most often limited to patients who attempted suicide. As experienced by the last author when he worked as a resident in internal medicine in the early 90's, in such situations the psychiatrist came and left, sometimes leaving a note or just stating "the patient can go home after receiving medical treatment". This PC model with psychiatrists working outside the hospital had many disadvantages, including the fact that patients with other than severe and obvious psychiatric disorders remained undiagnosed and untreated due to a lack of exchange between the medical and psychiatric discipline. The birth of the so-called psychiatric liaison (LI) activity, namely the work of psychiatrists with their somatic colleagues, then aimed to compensate for this lack (1). In the beginning, LI's purpose was to sensitize clinicians to the

psychological dimension of their patients and hereby increase referral. The general hospital started to integrate psychiatrists who incarnated the psychological dimension of illness, and reminded by their very presence the psychological suffering of the medically ill. The further development of specialized services with more human resources and visibility increased referral but not adequacy of the indication for referral. For example, the last author still faced at the beginning of his professional career as a liaison psychiatrist requests like “patient is crying”. To remedy that problem, LI attempted, through activities like teaching or implementing psychometric screening instruments, to help referring physicians to refine their indications so as to increase psychiatrists’ efficiency. Despite these efforts, epidemiological investigations such as the multicenter European Consultation and Liaison Workgroup’s study (2) revealed that psychiatric consultations were initiated for too few patients, occurred too late during their hospitalization, and were more oriented by the needs of the clinicians than those of the patients. In this regard, it has been observed that LP still resembles emergency psychiatry, intervening for “noisy” and thus “disturbing” patients whose conditions were not immediately treatable (e.g., personality disorders), while “cooperating” and “silent” patients (e.g., depressed or affected by hypo-alert and hypo-active delirium) did not benefit from psychiatric consultations. Referral to LP is a complex issue and depends on various factors that may be related to the patients (anosognosia, masking of distress or somatic expression of psychiatric disorders, etc.) or to the clinicians (lack of training, defensive attitudes towards the psychological suffering of the medically ill, etc.), and on determinants in relation with the institution (lack of continuity of care, focus on medical problems, etc.) and the sociocultural context (stigmatization of psychiatric patients, shame associated with psychiatric morbidity, etc.). As referral, the screening of patients is a complex and unresolved issue for LP. While an in-depth discussion of the benefits and limits of screening is beyond the scope of this paper, we would like to illustrate possible ways of proceeding with the example of a LI intervention with the INTERMED. The Swiss National Accident Insurance funded rehabilitation clinic (SUVA) in Sion has indeed adopted since almost twenty years this biopsychosocial assessment system (INTERMED) to detect patients in need of interdisciplinary and psychiatric treatment (3). The

INTERMED, based on the concept of biopsychosocial case complexity and scored using a semi-structured interview (or patient self-assessment), has shown to identify patients with medical and psychosocial morbidities, who are at risk of benefiting less from medical interventions compared to non-complex patients. The INTERMED has thus been used as an effective means to target patients who benefit from LP; such targeted interventions were demonstrated in randomized clinical trials to increase patients' quality of life, and to decrease their psychiatric morbidity and health care utilization upon follow-up (4). Along these efforts, LI has also promoted more systematically individual and group supervisions, which are another way to increase clinicians' psychological competences and to support them in their daily work.

From our viewpoint, up to now LI interventions pursued four objectives: the sensitization of clinicians for the psychological suffering of the medically ill, the refinement of indications for psychiatric referral, the systematic identification of patients benefiting from liaison psychiatry, and the support of clinicians. Depending on local resources and on settings, these objectives are fulfilled to different degrees.

So far so good. On closer inspection, however, it seems to us that LI suffers from being marginalized, shows an inability to adapt to the evolution of clinical practice, and lacks empirical foundation, as we will see in the following. Moreover, LI is not a formal part of the training of liaison psychiatrists, and most of the liaison psychiatrists are absorbed by the PC activity. The fact that many activities of LP are not sufficiently reimbursed, hampers their development; this is especially the case for LI.

We also can observe that after the introduction of supervisions and Balint groups (5) only a few other types of LI interventions have been developed and widely implemented. An example are communication training programs, which are however almost exclusively intended for oncology professionals (6). Communication training is a powerful tool to address clinicians' preoccupations when encountering patients and to increase their communicational and relational competences (7, 8). However, these are punctual interventions, addressing a specific population of professionals and

particular problems. Furthermore, while clinicians are situated, which means that they are part of a context (institutional, cultural, social, and societal), LI interventions solely address psychological dimensions of their work; the contextual determinants of their experiences are not dealt with traditional LI interventions (9,10).

While PC activity can rely on a body of scientific evidence, investigation of the LI is almost non-existent. Individual and team supervisions, for example, which are among the main activities of LI remain largely under-researched (11).

Finally, training of future liaison psychiatrists focuses on PC activities; residents may occasionally participate in supervisions provided by a senior liaison psychiatrist but they then learn LI by doing.

The LI approach at Lausanne University Hospital

There are possible remedies to these shortcomings. In our Service, we have for example initiated a research line that we call clinician-centered research with studies on clinicians' matters of interest, satisfaction and concern or, in other words, on experiences of practicing medicine and being a clinician (12). This research is nourished by the contribution of social scientists (socio-anthropologists, linguists, and a philosopher) embedded in the Service permanently or in connection with research grants, working hand-in-hand with clinicians-researchers from liaison psychiatry. Examples of topics investigated over the past years are: physicians' relationships with themselves, patients, peers and the health care, institutional and social context (13); the rise and fall of trust in oncological consultations (14); the role of calling in medicine (15); dreams of medical students (16); daily work experience of internal medicine residents (17); perception of individual supervision focused on links between professional and private life (18); and the impact of own illness experience on physicians (19). Overall, these studies show that physicians are dedicated to their profession and sensitive to patients' suffering, but they feel torn between their clinical and prosocial intentions and the institutional constraints (e.g., pressures for clinical productivity, bureaucracy, etc.). Furthermore, their own psychological factors and biography play a major role when they have difficulties in the encounter

with patients. These results underline that effective LI should address these issues related to the "outer" and "inner" world of clinicians. This research line almost exclusively uses qualitative research methods and approaches. As a next step, we will transfer the produced knowledge into our LI activity, try to find new ways to work with clinicians, surpassing the traditional supervisions, and integrate study results in undergraduate teaching.

From our point of view, this (still) small body of clinician-centered research can contribute to fill LI interventions with contents that are meaningful for clinicians, shape the pedagogical methods accordingly, and adapt LI interventions to the evolution of medicine and the changing profession of clinicians. Once these objectives achieved, formal training of future liaison psychiatrists should also be considered.

In order to illustrate how LI can be improved and effectively evolve by using new intervention approaches, we will shortly discuss the example of the PENbank (Professional Experience Narrative bank) (20).

The PENbank, developed as part of a Spark grant from the Swiss National Science Foundation (CRSK-3_190887/1, 2020–2021 https://p3.snf.ch/project-190887) with the aim to collect physicians' narratives about their lived experiences in the hospital, serves as an observatory providing voice and visibility to physicians' experiences and feedback to hospital management authorities, as well as a data resource for researchers.

The PENbank takes the form of a website (at the URL https://penbankchuv.ch/) allowing physicians of the CHUV and Unisanté to securely and anonymously send oral, written, or visual narratives recounting their experiences. Narratives are then stocked in a secure repository. The collected narratives are regularly visibilized. For example, the PENbank has a monthly column in the CHUV's electronic newsletter, which is received every Friday by about 13,000 people, and is featured in the Instagram stories of the CHUV. Furthermore, three winning narratives from the ninety-nine word stories challenge organized for the official launching of the PENbank were publicly displayed on

posters throughout the hospital site. Enhancing the understanding of the challenges physicians face in practicing medicine by visibilizing their experiences hopefully contributes to a more realistic and adequate relationship between physicians, other hospital collaborators, patients, their relatives and significant others, and the public. For example, an analysis of narratives collected during the first wave of the Covid pandemic identified the psychological challenges front line physicians had to face and how they adapted or maladapted to the situation. These results were presented to the senior staff members of the Internal Medicine Division to provide them with clues to identify physicians who might be at risk to be overwhelmed by the task (21).

The PENbank as an institutional intervention exemplifies both how to develop and structure LI when resources are limited and how to create new ways of reaching out to clinicians. The PENbank can be considered as a LI intervention on different levels. On an individual level (micro-liaison), it allows clinicians to recount their lived experiences, which is a means to reflect on their daily work life, to express what affects them, and to give voice to these professionals who are constantly subjected to expectations, institutional prescriptions, and projections. On a collective level (macro-liaison), the PENbank material can be used and has been used to raise awareness among senior staff members of clinical services on how physicians face challenges. On an institutional level (meso-liaison), making physicians' narratives visible has provoked many positive reactions among physicians and health care professionals who were hereby enabled to access or, ultimately, identify with experiences of colleagues. The next step will be to bring physicians' narratives into the city and the society (meta-liaison) with the aim to reach the population and engage in dialogue between physicians, PL researchers and clinicians, and the public.

This example illustrates how LI can evolve by adopting a systemic perspective and develop supportive interventions, which address and eventually modify institutional and social determinants of clinicians' experiences.

Academic developments

The academization of LI heavily relies on qualitative and interdisciplinary methods and approaches to provide a thick description of clinicians' experiences, and on the theoretical and methodological competences of social scientists to explore such issues, especially because social evolutions seep into medicine and into the task clinicians have to fulfill. This is the reason why the Faculty of Biology and Medicine of the University of Lausanne and the CHUV have decided to create an academic position, a professorship for LI. This position, occupied by the first author, aims to (i) consistently carry on clinician-centered research with the help of an interdisciplinary team, (ii) translate these research results into LI interventions, (iii) innovate LI interventions and adapt them to the evolving context and profession of clinicians, and (iv) bridge the gap between the psychological and the social, which impact clinicians. We are convinced that the academic investment of LI will allow to get it out of the shadow of the PC activity and, at the same time, send a strong message to clinicians that the hospital cares for those who care.

Conclusions

Both activities of PL, namely PC and LI, are needed to improve the psychological, psychiatric and psychotherapeutic care of the medically ill. Supporting clinicians is, however, not only a way to improve patient care, but also an imperative in times when clinical professions experience increasing pressures as illustrated by disturbing high resignation rates. While the call for patient-centered care has meanwhile been widely heard, the care of those who care for the patients is still in its infancy. We are convinced that the contribution of LI in this regard can be of paramount importance; it implies to consider LI as important as PC within PL.

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